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Title:

Community mental health nurses' and compassion: an interpretive approach

Accessible summary**What is known on the subject?**

- The concept of compassion is well documented in the health care literature but has received limited attention in mental health nursing.

What this paper adds to existing knowledge?

- Mental health nurses struggle with defining compassion. The study, with its limitations, brings greater clarity to the meaning of compassion for community mental health nurses and NHS organisations.
- Mental health nurses need time to reflect on their provision of compassionate care.

What are the implications for practice?

- The study has shown that compassion is important for NHS health care management, frontline mental health nurses and policy makers in the UK and there is potential for sharing practice and vision across NHS organisations.
- Mental health nurses could benefit from training in compassionate practices to facilitate their understanding of compassion.
- Emphasis should be placed on the importance of self-compassion and how this can be nurtured from the secure base of clinical supervision.

Key Words

Compassion, community mental health nursing, naturalist, interpretivist methodology, thematic analysis, emotion

Abstract

Introduction: There is increasing emphasis in policy, research and practice in the UK and internationally on the importance of caring in health care. Compassion needs to be at the core of all health care professionals' practice. Recently health care has received negative attention through media and government reports which cite a lack of compassion in care. Rationale: The concept of compassion has received limited attention in community mental health nursing. Aim: Based on data taken from semi-structured interviews with community mental health nurses this paper aims to describe interpretations and perspectives of compassion to gain insight and development of its meaning. Method: A naturalistic, interpretive approach was taken to the study. Semi-structured interviews with nine mental health nurses were analysed using Burnard's (1991) 14-step model of thematic analysis. Findings: The research illuminates the complexity of compassion and how its practice impacts on emotional responses and relationships with self, patients, colleagues and the employing organisation. Participants identified difficulties engaging with compassionate practice whilst recognising it as a driving force underpinning provision of care. Implications for practice: Mental health nurses need to be supported to work towards a greater understanding of compassionate care for clinical practice and the need for self-compassion.

Relevance statement

Mental health nurses can experience work-stress resulting from the multifaceted demands of their role, which affects their emotional well-being. Consequently, they require support when working towards a greater understanding of compassion and its fundamental requirement for clinical practice and the absolute necessity of self-compassion. This can be achieved through the personal and professional development aspects of clinical supervision.

Introduction

There is increasing focus in policy, practice and research about the importance of caring in healthcare. This has been fuelled by widespread concern over the failings of some healthcare workers and the National Health Service (NHS) in the UK. Several high-profile reports have indicated that lack of compassion could be a major contributing factor (Darzi 2008, Berwick 2013, Francis 2013). Similarly, there is evidence internationally and from European studies that an over emphasis on productive efficiency in health services can undermine compassionate care and foster cynicism in healthcare workers (Sinclair *et al.* 2016). This is unfortunate given that being 'cared for' compassionately is described as one of the most effective interventions in health care when given and received positively (Stone 2008, Youngson 2012).

The purpose of this paper is to present the findings from a qualitative study that explored the meaning of compassion for community mental health nurses and the factors that influenced their perceptions and beliefs about compassionate practice. The aim of the research was to provide an in depth and interpreted understanding of the community mental health world in which the research participants worked, seeking to make sense of their experiences and perspectives of compassion through the collection of detailed, rich data. The paper starts with an overview of pertinent literature.

Background literature

There is a paucity of literature explicitly relating to compassion within mental health and community nursing. Existing literature shows a lack of clarity on how compassion is represented and understood as a concept (Dewar 2011, Spandler & Stickley 2011, Brown *et al.* 2013) and its function in mental health. A cohesive definition of compassion has not yet been adopted or agreed in healthcare (Gilbert 2009, Lee *et al.* 2012). Although at face value some of this variance can appear trivial with limited impact on care, Dewar (2011) advises that front-line practice differences are crucial to the delivery of compassionate care. This is significant as healthcare workers' values and beliefs translate into differences in perspectives

and approaches, which can ultimately lead to unhelpful coping mechanisms and variations in care (Beckett 2013). When health care workers make assumptions about the meaning of compassion this further complicates the full depth and complexity of the concept. Further critical insight into these varying understandings and assumptions are vitally important for mental health nurses to help prevent variations in approaches to care provision (Beckett 2013), which might not always be in the patient's best interests. A lack of continuity of care or carer for example could expose patients to variations in approaches to compassionate care.

Gilbert (2009) states that for a person to experience compassion they must recognise suffering in another and have the desire and motivation to ease that suffering. This description is akin to the teachings of the Dalai Lama and Buddhist philosophy which Gilbert describes as underpinning his theory. Likewise, Dewar & Christley (2013) describes compassionate care as a complex process involving the experience of giving and receiving care. Attention is drawn to reciprocity and the significant impact this has on the outcome of compassionate relationship centred care. Reciprocity, where behaviours and emotional responses are congruent (Armstrong *et al.* 2000, Dewar & Christley 2013), goes beyond fulfilling a role lacking sincerity (Davidson & Williams 2009). A desire to relieve the distress on the part of the carer must be present to fully meet the criteria of a compassionate relationship (Dietze & Orb 2000, Perry 2009, Cole & Gilbert 2011, Gilbert *et al.* 2011, Germer & Neff 2013).

Various authors across healthcare professions have reported that those working in compassionate ways are more equipped to identify the unique needs of an individual (Peters 2006, Lee *et al.* 2012, Spandler & Stickley 2011) making care more person centred (McCormack & McCance 2016) and therefore recovery focused (Brown *et al.* 2013). The studies by Spandler & Stickley (2011) and Brown *et al.* (2013) were based in a mental health setting and therefore especially relevant. Spandler & Stickley (2011) state that compassion is vital in the process of understanding and identifying the unique needs of the individual generally but also in learning to appreciate what hope means for that person. Working in a

compassionate manner can enable mental health nurses to support the patient's recovery journey in a meaningful and fulfilling way. Relationships are therefore key with a need for the mental health nurse to be insightful to their impact upon that process.

The provision of care is inherently linked to moral values and practices. Compassionate care is a way in which non-maleficence can be achieved leaving patients 'psychologically intact' (Perry 2009, p.17). An important aspect of the mental health nurse's role is to assist another in their personal development within the context of their complex needs. This aligns closely to the philosophy of recovery within mental health (Barker 2008, Spandler & Stickley 2011) and the Millan principles which underpin the Mental Health (Care & Treatment) (Scotland) Act 2003 (Scottish Executive 2003). Recovery, like compassion, has a multitude of meanings. However, the overarching themes relate to the patient developing their own identity, being empowered, and supported to gain hope and take positive risks (Bonney & Stickley 2008). Parallel to this is a growing need for health care practitioners to feel safe and cared for so that they too can care for patients (Smith *et al.* 2008, Hunter & Deery 2009) creating the compassionate, relationship centred care described above. This can be difficult because large numbers of health care practitioners are at the sharp edge of care working in heightened emotional contexts (Heffernan *et al.* 2010, Deery & Fisher, 2010). Some of the literature highlights the emotional risks and potential negative implications for working compassionately such as fatigue and burnout (Berg *et al.* 1994, Butterworth *et al.* 1999, Edwards *et al.* 2000). However, Stone (2008) has stated that some of the positive effects of compassionate relationship centred care such as increased motivation, satisfaction and commitment (Perry 2009) can inspire health care practitioners to facilitate improved care.

Compassionate care is highly valued by stakeholders in healthcare professions (Hunter & Deery, 2009, Brown *et al.* 2013). In terms of mental health there are impacts on outcomes for the person using services, the mental health nurse providing care, the service and to wider

society. This study intended to make use of context, influences and the unique perspectives of the participants to further understand compassion.

Study Design

This research was about understanding the meaning of compassion for community mental health nurses and the factors that influence their perceptions and beliefs about compassionate practice. The research took a naturalistic, interpretive approach and was concerned with exploring the meaning of compassion for community mental health nurses 'from the interior' (Flick 2009) taking the words of the mental health nurses as a starting point to explore the factors that influenced their perceptions and beliefs about compassionate practice.

Such research accepts that researchers need to distance themselves from objectivity and use subjective experiences to pursue the potential for shedding light upon complex and difficult human circumstances (Smith *et al.* 2008). According to Morse and Field (1996) data collected during interpretist or qualitative research can examine underlying assumptions and attitudes such as those held by community mental health nurses in relation to compassion. Likewise, qualitative methods give the researcher increased flexibility in eliciting responses giving the participants greater scope to answer as authentically as they see fit (Parahoo 2008, Polit & Beck 2011, Bryman 2012). The scientific need to control or measure behaviour was therefore rejected.

Research team and reflexivity

According to Madison (2005) the politics of positionality need to take account of the researcher's own power, privilege and biases. KB was working clinically as a community

mental health nurse in the busy mental health service where the research took place. She knew the research participants and was aware of their varying experiences. She collected the data and did the preliminary data analysis. The relationship between herself and the research setting was central as she was coming to the research from a position of 'knowing' and as such had 'insider' knowledge (Finlay & Gough 2008). Current and past experiences, values, feelings, knowledge, interpretations and responses, as well as the way events influenced KB, were all recognised as part of the data gathered during the interview process. Immediately after data collection methodological and reflective notes were recorded in a research diary which was often referred to when re-reading transcripts and during research supervision meetings with GS and RD. This enabled KB to question personal and professional prejudices and how these might influence what was happening in the study (Koch & Harrington 1998, Finlay 2002, Finlay & Gough 2008). Researcher reflexivity in the form of 'thoughtful, conscious self-awareness' (Finlay 2002 p.532) was therefore crucial to shaping the research study and researcher development.

A self-selecting convenience sampling method was used (Polit & Beck 2010, Bryman 2012). Permission was gained from the senior nurses to approach identified clinical areas. The researcher (KB) sent an email invitation to participate in the study to the senior nurse who subsequently cascaded the invitation to all staff within the CMHTs. Initial uptake was slow but improved when team members were prompted to respond by the senior nurse and reminded of the importance of the study. The research was time limited to one year for academic purposes and it was not possible to further develop the sampling strategy or recruit from other sites. None of the participants were coerced and they were clear that non-participation would not affect their work situation. Their participation was therefore voluntary and a pseudonym was assigned to protect anonymity.

Setting

The study was conducted at a busy NHS Board in the West of Scotland and covered a wide demographic area with urban and rural areas of deprivation and affluence. The study involved nine semi-structured interviews with community mental health nurses (five men and four women). Those who participated had extensive experience within health care and nursing and were representative of the CMHT's staffing profile. Demographic data was not collected from the participants. The team had remained unchanged but had been productive for a long time and was now approaching a period of change as several team members planned retirement.

Ethics

Ethical approval for the study was obtained from the University's School of Health, Nursing and Midwifery's Ethics Committee and from the NHS Research and Development Department. When gaining informed consent, discussion of the research helped KB to gain the trust of the participants from a research perspective. This was important given her 'insider' knowledge of the research setting. The staff care services and personal support systems that were available to staff within the NHS Board were drawn to the participants' attention in the event of any participant having unmet needs or questions of a clinical nature.

Data collection and analysis

The interviews were semi-structured with supplementary notes also being taken during the interviews. The interviews gave a positive balance between remaining focussed and enabling the participants scope for exploration within their responses. A semi-structured schedule, which was created from the themes identified through the literature review, was used and follow up questions were often asked to clarify issues and meanings with the participants. All interview and field note data were transcribed verbatim and returned to the participants to enable them to make amendments, additions or deletions.

Preliminary data analysis using a 14-step model of thematic analysis according to Burnard (1991) was undertaken by KB to identify key phrases and themes. Emergent themes were identified and, as analysis progressed, reconsidered and, in some cases, modified during research supervision sessions. The research did not aim to be generalisable but to have resonance for community mental health nurses regionally and internationally and the capacity to encourage the participants to further develop their understanding of compassion. The participants were not involved in analysis of the data as the study was time limited.

Findings

The participants in this study have provided a rich source of meaningful information indispensable to developing insight into the concept of compassion from within their sphere of community mental health nursing. Their understandings of compassion were often framed within a NHS context of limited resources and increased administrative work.

The findings are discussed in five key themes:

- 'the bread and butter stuff' - meanings of compassion;
- 'stifling compassionate services' - systems and workloads;
- 'the weight of the world on your shoulders' - compassion as an emotional response
- 'getting nothing back' and 'feeling manipulated' - patients with complex needs;
- 'looking after each other' - self-compassion and caring for others.

'The bread and butter stuff' - meanings of compassion

Participants were asked about their understandings of compassion from a community mental health nurse perspective. No consensus on the definition of compassion could be established

from the data, as the participants did not have firm personal definitions of compassion. This was not surprising given the findings in the literature review. Some of the participants' words indicated that compassion was an intrinsic part of their humanity and therefore existed prior to entering nurse training and many expressed a belief that compassion was fundamental to their nursing practice.

James, an experienced mental health nurse, stated that his personal understanding of compassion had always been crucial to his professional practice:

'It is absolutely basic, it is a value, it is a human value, I don't think you can do this kind of work without being compassionate' (James)

Fred, a CMHT nurse with significant clinical and managerial experience linked a person's perception of compassion to belief systems: *'it (compassion) very much depends on our own values'*. Fred stated that compassion was an emotion *'that drives you to care'* and Greg, a less experienced but nevertheless high achieving nurse both professionally and academically, saw compassion as: *'I am one human working with another human'* (Greg). Linda, one of the CMHT nurses suggested that nursing may not be an ideal career option for those who do not hold compassion as a core value,

I'm not saying you wouldn't come into nursing, but I don't think you should come into nursing because you then have to work at that and I think it is a bit difficult if your not that kinda caring and compassionate person (Linda)

Although the participants' words seemed to suggest that compassion is core and essential to their practice, they were much less clear on the meaning of compassion. Julie, a very experienced nurse, paused before answering the question 'how would you describe compassion?' indicating that she might have found difficulty answering the question,

That's a hard one because it's like... Well I think I know what it means. It's like sympathy and empathy... em... I'm not too sure. I suppose it's about having the time and the patience and the knowledge and the understanding to try and help an individual. (Julie)

Alice, an experienced CMHT nurse, also found it difficult to describe compassion,

'In my head it is something about empathy, it is something about being there with somebody, it is about support, it is about being non judgmental and understanding eh... and kinda I suppose... so nothing that is very scientific I don't think.' (Alice)

Greg's words suggested that it was important to focus on the positive aspects of sharing a patient's recovery and seeing change over time because of facilitating compassionate care,

'It is the bread and butter stuff. I certainly believe it is about, em...sharing and feeling in distress, whether it be physical or emotional pain. And on the flip side of that you know we can also share in the positive you know we don't always need to focus on the negative sharing of pain. Emotional pain, physical pain, em.. distress, I think the positive things – we see a person getting a wee bit better and kinda stages of recovery (Greg)

Walter, an experienced CMHT nurse, identified a link with empathy:

"I suppose really just kinda like being empathetic you know I just sort of caring for people the way you would like your own relatives to be cared for and showing compassion and a level of empathy and trying to put yourself in that person's position" (Walter)

Becky also an experienced nurse, described empathy as part of compassion but noted how difficult it is to explain her understanding stating that: *'it's hard to kinda break down into actual*

words, there is this feeling'. The clearest definition came from Linda who had over 30 years' experience in various roles, currently a staff nurse within the CMHT. She stated,

'You can show sympathy or whatever but I think compassion is that you're trying to understand them [patients]. You are trying to be with them, you know you're not belittling their experience and how difficult it can be for them' (Linda)

One of the aims of this study was to explore community mental health nurses' perceptions of compassion, not to attempt to achieve a definition but an understanding of the various perceptions and experiences of the participants. Interestingly even the most academically accomplished and the most experienced community mental health nurses struggled to articulate what compassion meant for them. However, agreement that compassionate care is necessary was evident within the words of the participants.

'Stifling compassionate services' - systems and workloads

Participants were asked how their practice had developed over time and were invited to give examples of when compassionate practice had worked or not. They acknowledged the role of systems and processes and how they contributed to their ability to be compassionate practitioners (or not). Increasing organisational demands had impacted on their workloads especially increased administrative work related to clinical governance.

Greg, one of the crisis CMHT workers described the impact of demanding days;

If you see someone early morning and you have a number of people to see through the day. I think it is always in the back of your mind you have a number of other people to see, sometimes you can be having a conversation with a patient and you know you always have it in the back of your mind 'I have got to see this person - write up these

notes - I have got to see that person' and that can be quite intrusive in my mind (Greg)

His words suggested that a fluctuating workload and meeting increased administrative demands could affect his approach to compassionate care practice.

Josh's words also relate to the effects of organisational demands on compassionate care giving. He suggests that *'the demands of the service affect how compassionate they [the CMHT nurses] will come across to their individual patient'*. Josh also recognised that patient perceptions of whole teams and organisational services might affect compassionate practice;

...with the amount of referrals we were getting and care we were having to carry out, I dare say that would affect a person's perception of how compassionate we are as a service, not just as an individual but as a service (Josh)

James, an experienced manager, voiced his concerns about the role of systems in supporting compassion, *'sometimes I don't think the systems create circumstances that allow people to be compassionate and empathic'*. Fred was also concerned that systems and processes could 'stifle' compassionate practice. Linda also acknowledged that NHS systems and processes were constraining with the potential to cause ill health, *'I suppose it is how you cope with pressure and how you deal with it'*.

'The weight of the world on your shoulders' - compassion as an emotional response

When considering compassion, there is overlap with emotional labour and emotion work (Hochschild 1983, Brown *et al.* 2013). The giving and receiving of compassion requires an emotional response (Firth-Cozens & Cornwell 2009) that goes beyond basic care, involving

generosity and genuinely experienced feelings of commitment and empathy (Frank 2004). Greg experienced guilt as an emotional response when he perceived he was not practising compassionately,

'In my practice I always try and find a way we can work with this person, can we do something, can we find something to work on? And unfortunately in some cases certainly not all the cases but that happens and you know... It does make us feel terrible' (Greg)

Julie's words also emphasised feelings of guilt when work was forgotten or missed,

'I think we tend to think I didn't do that, I feel dead guilty... because we miss things, we forget things' (Julie)

James' words suggested that the *'level of intensity you work at'* contributes to feelings of exhaustion. He also stated that he did not know *'quite how you survive through it'*. Linda used the word *'draining'* and Greg advised that it can be *'anxiety provoking'*. Julie, James, Linda and Gregg all describe emotional responses to the giving (or not) of compassion and how this can be onerous, tiring and stressful.

Walter noted similar responses but also stated that practising compassionately could be invigorating;

'it can be both tiring and invigorating you know it does obviously takes its toll you know, I mean some days you feel like you have the weight of the world on your shoulders'.

Alice talked about being self-aware and the importance of recognising the emotional impact of mental health nursing;

'I think it is a bit about that self-awareness... that...we all have or don't have or have

in bits and I think when you are working in a difficult and challenging job, which I think this is sometimes, it is difficult to... sometimes you need to stop and check where you are at' (Alice).

Alice's words indicate that without the time to reflect on practice a mental health nurse can become overwhelmed by the challenges of the role. Julie's words suggest that there appears to be a strong link between the person the participant is at home to the person they are at work.

I think I had said at the beginning about we all have stressful life events and then if that gets too much then we burn out so am I giving myself too much to do which might have an impact on me being able to be compassionate all the time and the reality is that's not going to happen... then you've got to go home and try and have a normal life (Julie)

Linda also discussed supporting colleagues to identify when their work life balance was causing them difficulties stating that '*it's about finding out if there is something going on at home that that person's not coping with that is making them less compassionate at work*'.

'Getting nothing back' and 'feeling manipulated' - patients with complex needs

The words of the participants in this study suggested that patients with complex, often multiple needs, can be a barrier to mental health nurses accessing their compassionate selves. Alice's words suggested that she believed herself to be unskilled in dealing with such patients. Her words indicated she was unable to engage on a relational level because of their communication style. She stated that;

'there is that again that kind of tension that you get with some people and I think it is

more difficult to be compassionate to people that you...that you don't feel so skilled with' (Alice)

Greg described a situation of '*feeling manipulated*' into generating what he thought was a clinically inappropriate outcome for a person to meet their complex needs;

'I suppose when a person may be desiring an outcome that may not be the outcome that we would be thinking would be the best for that person you know. The collaborative approach has broken down at that point. You know when the person has potentially other motives' (Greg)

Linda identified that she struggled with patients who she viewed as '*continually repeating patterns of negative behaviour*' and therefore '*not helping themselves to recover*'. She stated that '*it was not easy to be compassionate to someone like that...someone who's habitually not learning from their mistakes*'. James described his barriers with patients with personality disorder to stem from a lack of trust within the relationship and their '*erratic*' nature. He stated that he could '*not trust or rely on them because of the game they play...the ball changes and moves so much*'.

Greg and Linda talked about '*getting nothing back*' and '*nothing coming back*' and stated that they found it difficult to be compassionate when the patient did not appear to be helping themselves. Rejection or dependence on the part of the patient were seen by the nurse as being '*difficult*'. Greg's words highlighted the difficulties surrounding patients requiring consistent support when the CMHT nurses themselves are feeling the need to be needed.

'...for whatever reason you know, they consistently phone to express their distress and you are doing your best and they are kinda feeling... It is anxiety provoking for the nurse as well. Especially when you are offering that compassion and the recipient

doesn't seem to be taking it and is wanting so much more, whatever that may be from the nurse that they are having the contact with'. (Greg)

A sense of need was found in the words of the participants - Alice's need to feel skilled, James' need to feel safe, Greg's need to feel respected for his decision making, Linda's need for her advice to be adhered to and Julie's need to be cared for herself.

'Looking after each other' - self-compassion and caring for others

Self-compassion is a key theme within mental health work and especially important when considering compassion as an emotional response. Two key elements emerged in relation to how the participants managed their levels of compassion; awareness of the impact on home life and using peer support systems. Julie identified the role of home on work and vice versa, stating that at times she had had to take time off work to attend to her needs due to competing pressures,

'I think I had said at the beginning about we all have stressful life events in our own lives and then if that gets too much then we burn out so am I giving myself too much to do which might have an impact on me being able to be compassionate or maintaining that ability to be compassionate all the time and the reality is that's not going to happen... then you've got to go home and try and have a normal life' (Julie)

Fred, Linda and Alice similarly described the impact of home stressors on their ability to be compassionate. Linda highlights *'pressures outwith the job, what's happening in your own life'*. Fred comments that;

'I think that in various stages in peoples' lives depending on what they've went through; that compassion can be various levels of degrees where that if you're going through a

tough time yourself it may be difficult to be as mindful or compassionate with other people' (Fred)

Alice also stated that,

'Issues in home life and personal life when maybe you have an ill relative or whatever, and you get people with personality difficulties going on and on about something that you think ...is... I think that is difficult' (Alice)

Becky identified that the patients' needs may be close to the mental health nurse's own life experiences. Her words suggest that *'we are so close to that potential for transference and that may well affect the compassionate way we deal with that person'*. Linda discussed supporting colleagues to identify when their work life balance is causing difficulties stating that *'it's about finding out is there something going on at home so that person's not coping making them less compassionate at work'*. Becky's words suggested that the support of team members had been invaluable in helping the team develop and maintain compassionate practice.

'I suppose working in teams there's always this kind of working with others and looking after each other...I can only speak about my team, it is quite often informal supervision as well which is sometimes as useful because you get it at the time' (Becky)

James also thought that *'being able to speak to colleagues about it is really important'* and Julie stated that at times further assessment and /or clinical support is requested as *'a pair of fresh eyes'*. Fred stated that his colleagues would re-divide the workload *'maybe giving them a bit of support taking some work off them'*. The participants' words are suggesting that listening and sharing with work colleagues are important in building emotional skills and compassionate practice that is reciprocal.

Discussion

The findings from this study have highlighted that a collective understanding of compassion did not exist within a small community of mental health practice and that compassion is unable to be sufficiently understood beyond the perceptions of the individuals claiming to care compassionately. The data illuminate the complexity of compassionate practice and how it impacts on relationships the mental health nurse has with self, patients, colleagues and their employing organisation. This complexity is not confined to mental health nursing. Research and literature in other healthcare professions (Bolton, 2001, Hunter & Deery, 2009, Deery & Fisher, 2010, Walsh, 2010, Dewar & Christley 2013) has indicated that compassionate care is far less likely to emerge in contexts characterised by increasing organisational demands and where staff have no time to reflect on practice. The Francis Report (Francis 2013) highlighted an NHS organisational culture that is often based on a 'solipsistic view of human nature that is neglectful of relationships' (Fisher & Freshwater 2014 p.1) and a task based culture that prioritises meeting targets over the provision of models of practice that are centred around relationships (Deery & Fisher 2016). Participants in this study recognised compassionate practice as an emotional response and a driving force underpinning the provision of relationship based care but at the same time identified difficulties engaging with compassionate practice.

Many of the pressures that the participants were experiencing related to increasing organisational demands that defined their working life in terms of negotiating street-level bureaucracy (Lipsky 1980; 2010). As pointed out in Lipsky's (1980) seminal work, bureaucracies provide an organisational setting in which workers experience a combination of increasing caseloads, inadequate resources, the unpredictability of clients and uncertainty about the best way to approach their work with clients. Consequently, street level bureaucrats (mental health nurses in this case) develop patterns of care (or use their discretion) to manage

their workloads and organisational demands (Hupe *et al.* 2016). Lipsky (2010) believes that constraints on professional autonomy under increasing NHS organisational demands and the stress created between professional expectations and everyday street level reality can be a contributing factor to workplace stress and a questioning of professional role identity (Apker *et al.* 2006). This is consistent with some of the findings in this study where organisational and practical constraints impacted negatively on compassionate care giving.

Several authors have highlighted the impact of increasing workloads and competing resources within the context of work-related stress (Shapiro *et al.* 2007, Lipsky 2010, Wright 2014, Hupe *et al.* 2016). In this study competing demands on, and of, the participants placed them under enormous pressure to control their work situation, where compassionate practice often became inhibited, contributing to compassion fatigue (Shapiro *et al.* 2007) and inappropriate emotional responses such as guilt. Some of the participants viewed compassionate care as process that involved them investing energy in managing and modifying their emotional responses and which often involved hard work on their part. Patients with complex, and often multiple needs, were described by the participants as challenging and requiring more emotional effort or compassion (Bos *et al.* 2012).

'People' professions require a flexible range of emotional responses to be compassionate which can leave health care practitioners feeling emotionally drained thus affecting their home lives. This concurs with Hurley (2009) who describes personal and professional identities as being 'linked'. The impact of work on home is well acknowledged (Shapiro *et al.* 2007, Lombardo & Eyre 2011) and subsequently the need for a healthy work life balance (Wilson & Crowe 2008) to sustain working in a busy, stressful NHS environment. To sustain compassionate practice, the participants indicated that they needed to be insightful to their own needs and sufficiently care for themselves to care for others. This ability to self-manage, is a key attribute of the compassionate person (Jezuit 2002, Shapiro *et al.* 2007, Gilbert 2009). Participants stated that they sought practical, professional and interpersonal support from their

fellow team workers which had been invaluable in developing and maintaining their compassionate practice. Such positive team support has been shown to create open discussions between team members in previous research (Jezuit 2002, Apker *et al.* 2006, Wilson & Crowe 2008).

The view that nurses must care for themselves to adequately meet the needs of their patients is well documented (Altschul 1972, Faugier 1998, Barker 2008) but this can become difficult in a NHS culture where clinical issues and indeed the nurse's emotional responses to their work are overshadowed by issues relating to managerial hierarchy and organisational demands (Sloan 2006). with little time and space to reflect upon and develop clinical practice, there is likely to be negative repercussions on the quality of mental health services.

Conclusion

Current literature on the concept and interpretation of compassion within the area of mental health nursing is limited but has resonance with other professions such as nursing and midwifery. The belief that compassion is fundamental to mental health practice was collectively expressed as was its emotionally challenging nature with subsequent impacts on work life balance and stress levels for the participants. The research illuminates the complexity of compassion and how its practice impacts on relationships the mental health nurse has with self, patients, colleagues and their employing organisation. Participants identified difficulties engaging with compassionate practice whilst recognising it as a driving, emotional force underpinning provision of care.

The limitations of the study

This study has focussed on a small sample of community mental health nurses working in a mental health directorate in one NHS Board in Scotland. Nonetheless its tentative findings have implications for mental health nursing communities globally. KB worked with some of the

participants which could have affected responses to questions during the interviews. Elements of bias could also have been introduced through self-selection to the research (Polit & Beck 2011) as this imposes extra demands on participants in an already busy NHS context. This research was completed as part of a Masters research degree and therefore time and resources were limiting factors to the study.

Implications for practice

Future research is required to uncover the ways in which, and methods used, to convey compassion in mental health nursing and other NHS contexts. For compassion to be practised self-compassion is equally important because this can help to protect mental health nurses against the negative consequences of stress, disconnection, negativity and being judgmental to others and themselves (Gilbert 2009). The implementation of self-help mechanisms founded on compassionate principles (Barron & Sloan 2015) such as clinical supervision and mindfulness have been identified as ways to support NHS staff. A clear message from this study is their potential value to the development, maintenance and continued growth of compassionate care provision.

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